ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting Provider License No. _____

Phone ( ) _____

Name_____

Address_____

City/State/Zip_____

Provider Medicaid Number _____

(9-digit provider number is required)

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

_____

_____

3. Brief Dental/Medical History:_____

_____

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_____

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When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential."
Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032